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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 4.16-A
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State of MICHIGAN

COOPERATIVE ARRANGEMENTS WITH STATE HEALTH AND STATE VOCATIONAL REHABILITATION AGENCIES AND WITH TITLE V GRANTEES

I. MICHIGAN DEPARTMENT OF PUBLIC HEALTH

Agreement, effective December 26, 1980

II. MICHIGAN DEPARTMENT OF MENTAL HEALTH

Agreement, effective September 22, 1977

III. MICHIGAN DEPARTMENT OF EDUCATION, BUREAU OF REHABILITATION

Interim agreement, effective September 30, 1980

IV. MICHIGAN DEPARTMENT OF PUBLIC HEALTH, AND MICHIGAN DEPARTMENT OF STATE POLICE, FIRE MARSHAL DIVISION

Agreement, effective May 24, 1979

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CONTRACT BETWEEN THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES AND THE MICHIGAN DEPARTMENT OF PUBLIC HEALTH

Pursuant to Act 280, Public Acts of Michigan of 1939, as amended, a Medical Assistance Program has been implemented in the State of Michigan as authorized by the federal Social Security Act, as amended.

In order to fully comply with the provisions of the above legislation, with reference to appropriate and related federal requirements and with the mandates of Executive Order No. 1965-29 dated December 9, 1965 and subsequent attachments thereto, this contract is entered into by the Michigan Department of Social Services, hereinafter referred to as "Social Services" and the Michigan Department of Public Health hereinafter referred to as "Public Health".

ARTICLE I

It is the intent and purpose of the parties hereto, by entering into this contract: to promote high quality health care and services for recipients under the Medical Assistance Program; to comply with state and federal statutes, regulations and guidelines requiring the proper expenditure of public funds for the administration of a Medical Assistance Program and certification of health care providers; to provide a mechanism for prior authorization of selected services; to assure that the services provided under Title XIX and Title V are consistent with the needs of recipients and the two programs' objectives and requirements.

ARTICLE II

The Directors of Social Services and Public Health shall designate from their staffs appropriate liaison persons whose responsibilities shall include regular and periodic communication about the programs and operations described in this contract. Overall liaison responsibilities shall be vested in the Director of the Medical Services Administration, Social Services, and the Chiefs of the Bureau of Health Care Administration, and the Bureau of Personal Health Services, Public Health. These persons may delegate liaison responsibilities for programs or operations specified in the sections of Article III, below.

The liaison persons shall be responsible for the joint planning of relationships between the two agencies. They shall oversee the investigation of any problems that arise from the operation of this contract. They shall cause to be undertaken annually a review of the effectiveness of the working relationships defined in this contract, and shall initiate jointly any amendments to this contract.

ARTICLE III

The broad fundamentals of responsibilities and duties of the parties to this contract are subject to the terms and conditions contained in the sections below.

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are incorporated as covered services under Michigan's State Plan for Medical Assistance.

1. Hospitals, including public and private psychiatric hospitals and psychiatric units of general hospitals.
2. Nursing homes.
3. County medical care facilities.
4. Hospital long-term care units.
5. Nursing care units in state MI/MR institutions.
6. Home health agencies.
7. Laboratories.
8. Ambulance services.
9. Freestanding surgical outpatient facilities.
10. Physical therapy clinics and physical therapy practitioners.
11. HMOs.

PUBLIC HEALTH WILL:

1. At appropriate intervals as prescribed by state and federal regulations, conduct on-site surveys, re-surveys and other necessary examinations of the providers identified above applying to or already participating as providers of service under the state's Medical Assistance Program, for purposes of determining their compliance with program requirements for certification as providers.
2. Certify and recertify to Social Services, in accordance with federal regulations and the Michigan Public Health Code, those providers which meet applicable federal and state statutes and regulations. The methodology of survey, evaluation and certification will also comply with applicable statutes, regulations and the provisions of this section and be subject to review and comment by Social Services.
3. Notify Social Services and the individual provider within 5 working days of a certification determination and 30 calendar days prior to the expiration or automatic cancellation date of a time limited certification. Such notifications shall be made by a document process mutually agreed upon by both departments and shall include information sufficient enough in detail as to allow Social Services to carry out appropriate provider agreement action as mandated by federal regulations. This document process shall also allow for extensions of existing certifications as provided for in federal regulations.
4. Annually provide to Social Services a complete listing of all certifications in effect on January 1 of that year.
5. Determine and authorize any waiver of provider requirements granted, the conditions of the waiver and the time period such waiver will be in effect.

Vernice Davis Anthony, Director
Michigan Department of Public Health

Date

for Gerald H. Miller, Director
Michigan Department of Social Services

Date

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6. Maintain on file for three years all information and reports used in determining a provider's compliance with certification requirements. Such reports will include copies of the findings of those making on-site inspections, documentation of deficiencies and copies of official notices of waiver of any requirements.

7. Provide an appeal procedure for use when the provider is in disagreement with the evaluation of its compliance with certification requirements.

8. Delineate and approve the scope of services to be provided by health facilities, institutions and agencies as follows:

   a. With the assistance of appropriate professional organizations and agencies, develop standards and criteria for the provision of services by hospitals, nursing homes, medical care facilities, agencies, laboratories and other health facilities, institutions and agencies certified to provide care and services under the Medical Assistance Program.

   b. With the assistance of physician staffs *and* boards of trustees, as well as specialty consultants *and* local health officers as indicated, apply those standards *and* criteria to health facilities, institutions and agencies desiring to become providers of services under the Medical Assistance Program and other programs administered by Social Services.

   c. Certification shall include delineation and approval of the type of services and level of care, where applicable, which each facility or agency shall be authorized to provide under the Medical Assistance Program.

9. Provide to Social Services upon request and on a timely basis all reports necessary to meet federal reporting requirements.

10. Maintain data reporting procedures for determining expenditures in which federal financial participation is available.

SOCIAL SERVICES WILL:

1. Utilize as one of the determinants for provider enrollment, disenrollment and payment purposes the certification of providers or denial of such certifications made by Public Health to assure that reimbursement is made for health care and services rendered by providers meeting minimum accepted standards including the fire safety inspection.

2. Exercise ultimate authority to enroll or disenroll provider facilities and agencies in the Medical Assistance Program.

C. Prior Authorization, Medical Review and Independent Professional Review (MR/IPR)

This section provides for interdepartmental and multidisciplinary professional review and evaluation of the health status and care needs of eligible or potentially eligible Medical Assistance clients prior to and periodically following admission to skilled nursing and intermediate care facilities except those facilities for which MR/IPR has been contracted to the Michigan Department of Mental Health (MDMH) to perform for Social Services. In addition, an evaluation shall be made of the appropriateness of care provided by the facility to the client, the facility's adequacy in meeting the client's current care needs and the necessity and desirability of the client's continued placement in the facility. The program shall be designed and operated to conform to requirements for

MR/IPR set forth in federal regulations. Scheduling will involve consultation with local office staff of both agencies.

PUBLIC HEALTH WILL, IN COOPERATION WITH AND WITH THE APPROVAL OF SOCIAL SERVICES:

1. Provide nurse personnel, and where appropriate, a physician to provide consultation to the team, to participate in the MR/IPR prior authorization, periodic and interval review and evaluation processes.

2. Provide a system for recommending the appropriate level of care to be prior authorized for eligible or potentially eligible recipients admitted to, or seeking admission to, certified skilled nursing or intermediate care facilities except those facilities for which MR/IPR is performed by MDMH.

   a. Specify, in agreement with Social Services, the medical information and documentation to be received as part of the application for prior authorization.

   b. Evaluate medical information and documentation received as part of application for prior authorization. Recommend to Social Services the level of care determination made for the individual client's needs. This determination serves as the medical justification for payment at that level of care.

   c. Notify Social Services, the facilities to which the client is or is about to be admitted, local health departments, and others as appropriate regarding the prior authorization of level-of-care recommendation.

   d. Within 5 working days of the recommendation, distribute the level-of-care recommendation to specified parties.

3. Provide a system of periodic and, as required, interval review and evaluation of Medical Assistance clients in skilled nursing and intermediate care facilities. Such reviews shall be performed at least annually in each facility with the schedule monitored by Social Services to insure compliance with federal regulations as well as Social Services' participation. The review and evaluation, conducted by a nurse and other appropriate personnel, shall include:

   a. Personal contact and observation of each client and a review of each client's plan of care and appropriate associated medical records.

   b. Consultation, when indicated, with the responsible attending physician and the utilization review committee chairperson or designated agent, in skilled facilities, and at the conclusion of each review a team exit conference with the facility administrator and other appropriate staff.

   c. Forwarding of facility reports to Social Services within 15 days after the end of the month in which the annual reviews were conducted.

   d. Contribution to the annual facility review reports by Public Health and Social Services inspection team members. These reports shall be transmitted to Social Services within 15 days of the close of the month in which the review was done.

4. Semi-annually consult with, and obtain continuing approval from, Social

Services with respect to the functioning of the program.

5. Provide Social Services with reports necessary to fulfill federal reporting requirements within time frames established by the two departments.

6. Provide Social Services with statistical reports on MR/IPR as may be required under Social Services responsibilities.

7. Maintain necessary Medical Assistance Program files to ensure appropriate continuity of program responsibility. Immediate access to files will be afforded to both Public Health and Social Services.

8. Provide professional testimony for administrative hearings and in cases of litigation on all disputed level-of-care determinations.

9. At the request of Social Services participate in meetings, including those with Professional Standards Review Organizations, or entrance and exit interviews with federal agencies, when discussion involves the MR/IPR program.

SOCIAL SERVICES WILL:

1. Participate in MR/IPR and provide social evaluations and assessment of alternatives to facility care for clients during the prior authorization, and annual inspection and evaluation process.

2. Assist clients and their families in locating necessary community resources and appropriate placements to allow for the implementation of alternate care plans recommended by MR/IPR personnel.

3. Forward a copy of each annual facility inspection report filed by the inter-disciplinary team leader to the facility and its functioning utilization review committee.

4. Take appropriate action on recommendations submitted by MR/IPR personnel.

5. Conduct administrative hearings to resolve formal appeals of disputed level-of-care determinations.

6. Participate in periodic program evaluations with Public Health as described in point 4 of the responsibilities of Public Health.

7. Maintain necessary files to ensure appropriate continuity of program responsibility. Immediate access to files will be afforded to both Public Health and Social Services.

8. Advise Public Health of meetings, including those with Professional Standards Review Organizations, or entrance and exit interviews with federal agencies, when discussion involves the MR/IPR program.

D. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

In order to promote a comprehensive, preventive health care system for children eligible for services under Michigan's Medical Assistance Program (Medicaid), to assure the proper expenditure of public funds for health care and services provided said recipients, and to conform with applicable state and federal requirements, this section provides for a program of early and periodic screening, diagnosis and treatment (EPSDT) for eligible Medicaid recipients under age 21

to ascertain physical and developmental abnormalities, and to treat, correct or ameliorate abnormalities and chronic conditions found.

EPSDT is defined herein to include, at a minimum, the following services mandated by federal regulation:

1. Informing eligible recipients of the availability of EPSDT services;

2. Health screening according to an established periodicity schedule;

3. Diagnosis and referral services;

4. Identification, informing, and referring of recipients eligible for Title V services;

5. Treatment for defects and conditions discovered, including services not otherwise available to other Medicaid recipients;

6. Transportation, upon request, to and from screening, diagnostic, and treatment sites; and

7. Documentation of the administrative process and clinical data resulting from these efforts.

Screening components, periodicity schedules, professional performance standards and review procedures, administrative procedures, and manuals will be developed by Public Health in mutual agreement with Social Services. Review procedures will be implemented in a manner consistent with the professional perspectives and responsibilities of the public health care system and in accordance with applicable federal and state statutes, rules and regulations.

PUBLIC HEALTH WILL:

1. Screening, Referral, and Follow-up

   a. Develop screening content, procedures and standards:

      Professional health staff will develop and recommend content, frequency, and standards for screening services and evaluation data in cooperation with other medical, dental, and health representatives as appropriate. Content and standards will include, but need not be limited to, all services required by federal regulations; additional services may be provided at the option of screening providers with prior approval of Social Services. Frequency of screenings will be based on a periodicity schedule developed to provide screening intervals appropriate to age and stage of development. Special consideration will be given to steps required to make services available to handicapped individuals.

   b. Assure the availability of screening services:

      The availability of screening services on a statewide basis and the delivery of services at the local level will be accomplished through contracts and subcontracts approved by Social Services. Each such (sub)contract is to be reviewed and renegotiated annually and must specify the responsibilities, staff and other resources, and a detailed budget conforming with section C, below. Public Health will forward a copy of the signed contract to Social Services. Screening sites may

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be located at local health department clinics. Designated staff will have responsibility for day-to-day operation of the screening functions, including administrative and clinical performance. Periodically, the operation of clinics statewide will be evaluated and monitored by Public Health staff through the analysis of reports, data and on-site visits as needed. Reports of significant negative findings, together with recommended corrective action, will be forwarded by Public Health central office to Social Services within 60 days of the completion of each such analysis.

The screening clinic will provide local Social Services with a schedule of available screening times at least one month in advance for use by Social Services in scheduling client appointment times and preparing daily screening schedules for the clinic. Clinic staff will notify Social Services, within one working day, of an individual's failure to keep an appointment by completing and returning the daily screening schedule.

c. Assure that the established services are provided and recorded:

1) Screening procedures will be performed by specially trained clinic teams, which are staffed according to formulas designed to assure adequate screening.

2) Results of each client's screening and any referral information will be recorded on a screening summary form, agreed to by Social Services, which will be sent to central office within a designated period of time after completion of the screening. Data from the summary will be placed on computer file after evaluation and an analysis by central office staff; Social Services generates the reports for use by Public Health central office and local health department staff in follow-up and monitoring activities.

3) Clinic staff will: a) screen clients; b) interpret results to families; c) assist in completing health history forms, when necessary; d) offer assistance to families in locating and selecting appropriate medical resources and arranging appointments as necessary; e) offer assistance in utilizing medical resources effectively; and f) identify those clients eligible for Title V services, referring them as appropriate.

4) Clients will be referred by the clinic to medical/health providers for further evaluation and treatment when indicated by screening results. Referral information (including the provider type and provider ID number of the provider to whom referral is made) and date of appointment will be recorded on the client's screening summary, prior to the form's submission to central office. Such referral data will be placed on computer file and periodically matched with the Social Services medicaid claims file to verify that treatment has been initiated. If no match is made, indicating treatment has not been initiated, a non-treatment report will be generated by Social Services and sent to the screening clinic for follow-up.

5) Upon receipt of a non-treatment report, clinic staff will follow-up with clients so referred to them and will prepare a outcome report identifying an outcome for each referral client. Follow-up will

also occur whenever a client chooses to make his/her own appointment.

2. Outreach, Training and Transportation

   a. Contract with local health departments or other health care delivery organizations for the provision of outreach and scheduling services with approval of Social Services. Such contracts are to be reviewed and renegotiated annually with outreach staffing allocated according to the formula in 3.d.2) below.

   b. Forward to Social Services proposals for outreach services at the local level with Public Health's recommendations for approval, rejection, or conditions of acceptance.

   c. Monitor outreach activities performed by local health departments and other health care organizations and report any significant negative findings and recommendations for corrective action, to Social Services.

   d. Provide training programs for, and the monitoring of, screening and outreach teams as needed.

   e. Offer assistance to families in arranging transportation for referrals. If transportation assistance is requested, clinic staff will inform outreach workers by forwarding a referral-for-services form; outreach workers then arrange transportation.

3. Fiscal Control, Documentation and Reporting

   a. Develop and implement budget proposal format and procedures which assure:

      1) Adequate detail to reflect the previous, current, and projected years' costs by agreed-to line items:

      2) Narrative explanation of each projected increase or decrease;

      3) Provision of a rationale for any budgetary increases; and

      4) Availability of work papers upon request.

   b. Submit all local contract proposals and significant budget amendments to Social Services, allowing a one month lead time for approval. Annual budget requests and any program revision requests shall be developed in cooperation with Social Services to facilitate consistency between the two department's budgets. All local EPSDT contracts shall be coincident in duration and termination date with the state fiscal year.

   c. Promulgate a formula agreed to by Social Services, for staffing patterns, to local health department clinics and other health-care providers involved in screening, outreach and transportation services. The standard formula follows:

      1) Clinic staff: One (1) clerk for every 4,000 contracted screening appointments, One (1) nurse for every 4,000 contracted screening appointments, One (1) technician for every 2,000 contracted screening appointments, One (1) budgeted nurse position for every 8,000 contracted screening and appointments for follow-up, One (1) clinic aide for every 4,000 contracted screening appointments (or more

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where previously approved) and sufficient staff for back-up to work a minimum of 4 hours per month to maintain skills. When contracted screening appointments total less than 4,000 per contract, staffing levels will be a percentage of the formula, as agreed upon by Social Services. 79-11

2) Outreach staff (when performed by Public Health): For every 1,000 contracted screening appointments at a given site, one outreach coordinator; for every additional 1,000 contracted screening appointments, one Public Health field representative; for every 4,000 contracted screening appointments, one full-time transporter and one full-time clerk.

e. Reimburse local contractors for actual costs incurred in fulfilling EPSDT (sub)contracts, such reimbursement not to exceed the amount of the local contract or the state EPSDT appropriation.

f. Develop and implement methods for the maintenance of financial records in accordance with currently accepted accounting principles. For each of the first three quarters of the year, report expenditures data, in the aggregate, to Social Services.

g. During the last quarter of the fiscal year, report expenditure data, by (sub)contract and in the aggregate, monthly to Social Services. Comparison of expenditures to approved budgets will be shown on these reports. If expenditures appear to be exceeding approved budgets for the fiscal year, corrective action must be recommended for Social Services consideration.

h. Provide Social Services with monthly information on screening results, including: clients screened, clients referred for diagnosis and treatment, and other information regarding screening and outcome required for effective program management, federal reporting requirements, and other written documentation which may be found necessary by either agency at the central or local level.

i. Require that overscheduling, at a rate of at least 25% over capacity, be allowed in clinics where average attendance is less than 80% of optium capacity.

4. Program Coordination

Designate a staff member to serve as EPSDT coordinator and liaison with Social Services.

5. Other Program Operations

Provide whatever assistance is necessary to Social Services, through outreach and scheduling activities and data collection, to ensure that federal requirements are met with regard to the informing of clients, completion of screenings within established time limitations, and identification of clients eligible for services under Title V programs.

SOCIAL SERVICES WILL:

Local staff will perform activities related to client contact (e.g., eligibility, outreach, and scheduling) and access to screening/referral services, and